STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001165	A. BLDG: 00 B. WING:	04/11/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LIBERTY EYE SURGICAL CENTER, LLC STATE LICENSE NUMBER: **17401501**	**9122 BLUE GRASS ROAD** **PHILADELPHIA, PA 19114**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 0000	INITIAL COMMENT This report is the result of a State licensure survey conducted on February 23, 2023, at Liberty Eye Surgical Center, LLC. It was determined the facility was not in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Ambulatory Care Facilities, Annex A, Title 28, Part IV, Subparts A and F, Chapters 551-573, November 1999.	S 0000		
S 033C		S 033C		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 033C	Continued from page 1 553.3 (3) Governing Body Responsibilities 553.3 Governing Body responsibilities include: (3) Assuring the facilities and personnel are adequate and appropriate to carry out the goals and objectives. This REGULATION is not met as evidenced by:	S 033C	The governing board met to discuss the citations and to educate themselves on their roles and responsibilities within the organization. They were educated on how the lack of their oversite led to the citations and they were educated on the center bylaws. The board voted to meet more often in an effort to stay more involved. The board currently meets in person once per quarter. They will continue with that schedule but will also meet on zoom once a month on the months with out the quarterly in-person meetings. The board educated the administrator, director of nursing and medical director on their roles. The administrator is responsible for human resource and credentialing practices. The director of nursing is responsible for medication storage and environmental care. The medical director is responsible for overseeing what the administrator and director of nursing is doing. In order to audit the progress of these changes the board voted to require an on-going agenda at governing	Completion Date: **06/30/2023** Status: **APPROVED** Date: **05/31/2023**

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S 033C	Continued from page 2	S 033C	board meetings including 1. Credentialing 2. New Employees 3. Medication Storage 4. Environmental Care. It will be the responsibility of the center administrator to include the 4 topics on each meetings agenda. It will be the responsibility of the medical director to ensure that 4 topics listed above are discussed.	

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S 033C	Continued from page 3 Based on observation, review of facility policies and procedures, documents, and interview with staff (EMP), it was determined the Governing Body failed to provide oversight of the facility practices to ensure the requirements of the license granted to the facility by the "Department" for the delivery of patient care services were followed. Findings include: Review of facility Bylaws "Governing Body Bylaws Of The Medical Staff Of Liberty Eye Surgical Center, LLC." dated January 1, 2004, revealed "Article II Functions: The Board shall act on behalf of the Medical Staff to coordinate the activities and general policies of the various services pursuant to the Medical Staff Bylaws and Rules and Regulations of the Medical Staff. The Board shall meet as often as necessary to perform its functions, but at least annually." The following events show a systemic nature of non-compliance with regards to the effectiveness of	S 033C		

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S 033C	Continued from page 4 the Governing Body as follows: a) 553.3(6): Tag 033F, Governing Body Responsibilities-failed to establish policies to verify professional licensure and written references prior to hiring licensed professional personnel. b) 553.3(8)(ii): Tag 033J, Governing Body Responsibilities- failed to verify professional licensure and written references prior to hiring licensed professional personnel. c) 555.2: Tag 5200, Medical Staff Membership-failed to comply with granting privileges to the medical staff in accordance with the facility's Bylaws and "Department" state regulations for a "Class B" ambulatory surgical facility (ASF). d) 555.3(d)(1): Tag 53D1, Requirements-failed to follow established facility policy for the recommendation of clinical privileges only after there has been a recommendation from the medical staff to the Governing Body.	S 033C		

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S 033C	Continued from page 5 e) 561.25: Tag 6142, Distressed Drugs, Devices and Cosmetics-failed to ensure outdated vials (open and unopened) of medications was maintained in a secured manner within the facility until disposal. f) 567.41: Tag 6744, Maintenance Service-Principle-failed to maintain and sustain the facility's safe and sanitary characteristics to minimize health hazards in the facility's Operating Rooms and Decontamination Room for the protection of employees and patients.	S 033C		
S 033F		S 033F		

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S 033F	Continued from page 6 553.3 (6) Governing Body Responsibilities Governing Body responsibilities include: (6) Adopting policies or procedures necessary for the orderly conduct of the ASF. This REGULATION is not met as evidenced by:	S 033F	2. Governing Board Members voted to approved changes to the policy titled "Personnel Files" to now include that license verification, education verification and 2 written references must be verified prior to an employees start date. The board also voted to edit the new employee check list to include license verification, education verification and reference verification. The Center Administrator was present at the governing board meeting and was educated on the policy and the new checklist to be used for hiring. The center administrator will be responsible for completing personnel files. New Employee files will be audited once per quarter by the medical director. The medical director will report their audit results quarterly at the QAPI and Governing Board Meetings.	Completion Date: **06/30/2023** Status: **APPROVED** Date: **05/31/2023**

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S 033F	Continued from page 7 Based on review of facility Bylaws, documents, policies and procedures and interview with staff (EMP), it was determined the Governing Body failed to ensure the facility established policies for verification of licenses and verification of written references prior to the date of hire for licensed personnel as required by the "Department". Findings include: Review of facility Bylaws "Governing Body Bylaws of The Medical Staff Of Liberty Eye Surgical Center, LLC." dated January 1, 2004, revealed "Article II Functions: The Board shall act on behalf of the Medical Staff to coordinate the activities and general policies of the various services pursuant to the Medical Staff Bylaws and Rules and Regulations of the Medical Staff. The Board shall meet as often as necessary to perform its functions, but at least annually." Review of facility document " Governing Board Meeting Minutes " dated March 10, 2022, revealed "GB (Governing Body) reviewed current QAPI,	S 033F		

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S 033F	Continued from page 8 Infection Control and Patient safety Plans, policies and procedures, GB voted to keep currents plans/policies in place with no changes. GB will review again in 2023." Review of facility policy " Personnel Files " last reviewed February 17, 2022 revealed "Policy: It is the policy of this facility to establish a personnel file on all employed individuals. The files for clinical employees will be initiated and maintained by the clinical manager according to information which is required by federal, state, or local regulations... Procedure: The personnel file will contain the following documents, as applicable, in the order listed: A. New Hire Documentation: Application waiver, Qualifications, CV/resume, I-9 with documentation. ...D. Licensure, Certification: License, Certifications (BCLS, ACLS, etc.), On-line licensure verification." Further review revealed there was no requirement for verification of professional licensure and written references prior to hiring licensed personnel in the facility's policy. An interview conducted on February 23, 2023, at	S 033F		

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S 033F	Continued from page 9 12:55 PM with EMP1 confirmed that the facility's policy did not contain a requirement that prior to the date of hire, verification of licenses and verification of written references for licensed personnel would be completed. Cross Reference: 553.3(8)(ii): Tag 033J, Governing Body Responsibilities	S 033F		
S 033J		S 033J		

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S 033J	Continued from page 10 553.3 (8)(ii) Governing Body Responsibilities 553.3 Governing Body responsibilities include: (8) Establishing personnel policies and practices which adequately support sound patient care to include, the following: (ii) Applications for positions requiring a licensed person shall be hired only after obtaining verification of their licenses, records of education, and written references. This REGULATION is not met as evidenced by:	S 033J	A Policy titled "Personnel Files" was changed at the governing board meeting that took place on 04/13/2023 to now include requirements for obtaining license and education verification along with written references prior to an employee starting. The center administrator will be responsible for completing new employee files. The Center Administrator was present at the governing board meeting and was educated on the policy. New employee files will be audited monthly by the medical director. The medical director will report their audit results quarterly at the QAPI and Governing Board Meetings.	Completion Date: **06/30/2023** Status: **APPROVED** Date: **05/31/2023**

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S 033J	Continued from page 11 Based on a review of facility policy, personnel files (PF) and interview with staff (EMP), it was determined that the facility failed to verify the licenses and written references of licensed registered nurses prior to the date of hire as required by the "Department" for two of two personnel files reviewed (PF1 and PF2). Findings include: Review of the facility ' s policy " Personnel Files " last reviewed February 17, 2022, revealed "Policy: It is the policy of this facility to establish a personnel file on all employed individuals. The files for clinical employees will be initiated and maintained by the clinical manager according to information which is required by federal, state or local regulations... Procedure: The personnel file will contain the following documents, as applicable, in the order listed: A. New Hire Documentation... 2 written references...D. Licensure, Certification: License, Certifications (BCLS, ACLS, etc.), On-line licensure verification."	S 033J		

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S 033J	Continued from page 12 1.Review on February 23, 2023, of PF1, a registered nurse hired on January 6, 2022, revealed the license of the professional registered nurse was not verified until September 22, 2022. Review on February 23, 2023, of PF2, a registered nurse hired on February 28, 2022, revealed the license of the professional registered nurse was not verified until August 30, 2022. An interview conducted on February 23, 2023, at 12:10 PM with EMP1 and EMP2 confirmed PF1 and PF2 did not contain evidence of documentation that the professional licenses was verified prior to the date of hire. _____ 2. Review on February 23, 2023, of PF1, a registered nurse hired on January 6, 2022, revealed no evidence of documentation that two written references were verified prior to hire.	S 033J		

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S 033J	Continued from page 13 Review on February 23, 2023, of PF2, a registered nurse hired on February 28, 2022, revealed no evidence of documentation that two written references were verified prior to hire. An interview conducted on February 23, 2023, at 12:35 PM with EMP1 and EMP2 confirmed that the facility had not verified a minimum of two written references for PF1, a professional licensed registered nurse and PF2, a professional licensed registered licensed nurse prior to hire. EMP1 confirmed the facility was not in compliance with the "Department" regulation for verification of written references for professional licensed staff prior to hire. Cross Reference: 553.3(6): Tag 033F, Governing Body Responsibilities	S 033J		

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S 033J	Continued from page 14	S 033J		
S 5200		S 5200		

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S 5200	Continued from page 15 555.2 Medical staff membership 555.2 Medical Staff Membership A member of the medical staff shall be qualified for membership and the exercise of clinical privileges granted to him. The governing body of the ASF, after considering the recommendations of the medical staff, may grant clinical privileges to qualified, licensed practitioners in accordance with their training, experience and demonstrated competence and judgement. Members of the medicals staff and others granted clinical privileges shall currently hold licenses to practice in this Commonwealth. This REGULATION is not met as evidenced by:	S 5200	The governing board was educated on requirements for a Class B ASF and they voted to remove Endotracheal Intubation from the anesthesia scope of care/request for privileges form. Governing board approved a new scope of care/privilege request form to be used effective immediately. Center Administrator sent revised privilege's request form to vice president of anesthesia company to distribute to all credentialed staff. GB voted to require all forms be signed and returned by 07/01/2023 or privilege's will be revoked. A letter educating the providers of the changes & requirements along with a copy of the new form has been mailed to all credentialed anesthesia staff and copies have been added to their personnel files. The center administrator will report any providers who did not return signed request for new privileges to the governing board at the scheduled meeting in June, 2023. At that time, the center administrator will contact those providers one more time in an	Completion Date: **07/02/2023** Status: **APPROVED** Date: **05/31/2023**

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S 5200	Continued from page 16	S 5200	effort to secure the documentation prior to the 7/1/23 deadline. The medical director will send a letter terminating privileges to any providers who did not return the new scope of care/request form on 07/02/2023. The medical director will audit new physician and CRNA files for approved privilege's monthly. The medical Director will report their audit results quarterly at the QAPI and Governing Board Meetings.	

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S 5200	Continued from page 17 Based on review of facility Bylaws, credential files (CF), and interview with staff (EMP), it was determined the facility failed to comply with granting privileges to the medical staff in accordance with the facility's Bylaws and "Department" state regulations for a "Class B" ambulatory surgical facility (ASF) for five of five credential files reviewed (CF1, CF2, CF3, CF4 and CF5). Findings include: Review of the facility's "Medical Staff Bylaws, Liberty Eye Surgical Center" adopted and dated January 1, 2004, by the medical staff revealed "Article VI Clinical Privileges: 6.1 Except as otherwise provided in these bylaws, a member providing clinical services at this facility shall be entitled to exercise only those clinical privileges specifically granted. These privileges and services must be organization specific within the scope of any license, certificate, or other legal credential authorizing practice in this state and consistent with any restrictions thereon".	S 5200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001165	A. BLDG: 00 B. WING:	04/11/2023

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S 5200	Continued from page 18 Review on February 23, 2023, of CF1, an anesthesiologist, revealed CF1 was granted privileges for "Endotracheal Intubation" by the medical advisory board member on December 30, 2022, and approved for medical staff reappointment by the Governing Board for a two-year period with privileges granted for "Endotracheal Intubation" beginning January 1, 2023, and expiring December 31, 2025. Review on February 23, 2023, of CF2, an anesthesiologist, revealed CF2 was granted privileges for "Endotracheal Intubation" by the medical advisory board member on September 17, 2021, and approved for medical staff reappointment by the Governing Board for a two-year period with privileges granted for "Endotracheal Intubation" beginning on September 20, 2021, and expiring September 19, 2023. Review on February 23, 2023, of CF3, a certified registered nurse anesthetist, revealed CF3 was	S 5200		

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S 5200	Continued from page 19 granted privileges for "Endotracheal Intubation" by the medical advisory board member on March 10, 2022, and approved for medical staff appointment by the Governing Board for a two-year period with privileges granted for "Endotracheal Intubation" beginning on March 10, 2022. Review on February 23, 2023, of CF4, a certified registered nurse anesthetist, revealed CF4 was granted privileges for "Endotracheal Intubation" and approved for medical staff appointment by the Governing Board for a two-year period beginning March 10, 2022, without approval by the medical advisory board member for privileges requested. Further review of CF4 revealed a document titled " CRNA-Anesthesia Scope Of Care" was not signed and dated by the medical advisory board member as required by the Governing Board for approval of the privileges requested by CF4 as delineated on the CRNA-Anesthesia Scope of Care document. Review on February 23, 2023, of CF5, an anesthesiologist, revealed CF5 was granted	S 5200		

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S 5200	Continued from page 20 privileges for "Endotracheal Intubation" by the medical advisory board member on December 31, 2021, and approved for medical staff reappointment by the Governing Board for a two-year period with privileges granted for "Endotracheal Intubation" beginning on January 5, 2022, and expiring January 4, 2024. An interview conducted on February 23, 2023, at 11:02 AM with EMP1, confirmed CF1, CF2, CF3 and CF5 was granted privileges by the medical advisory board member and the Governing Board to perform Endotracheal Intubation on patients at the facility. In addition, EMP1 confirmed CF4 was granted medical staff appointment without approval of privileges by the medical advisory board member as required by the Governing Board. Further interview confirm CF4 was granted privileges to perform Endotracheal Intubation on patients in the facility by the Governing Board without approval by the medical advisory board member. In addition, EMP1 confirmed the facility was a Class B facility and endotracheal intubation of patients did not align	S 5200		

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S 5200	Continued from page 21 with the facility's license granted by the "Department" as a Class B facility. Cross Reference: 555.3(d)(1): Tag 53D1, Requirements	S 5200		
S 53D1		S 53D1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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S 53D1	Continued from page 22 555.3 (d)(1) Requirements 555.3 Requirements for membership and privileges. (d) Granting of clinical privileges shall follow established policies and procedures in the bylaws or similar rules and regulations the procedures shall provide the following. (1) Written record of the application, which includes the scope of privileges sought and granted. The delineation "clinical privileges" shall address the administration of anesthesia. This REGULATION is not met as evidenced by:	S 53D1	The governing board and medical director were educated on what the bylaws dictate must be present in a physician/CRNA file. The medical director was educated on his role granting privileges to new physicians and CRNAs. The medical director will audit new physician/CRNA files monthly to monitor granted privileges. Those audit results will be reported quarterly at the QAPI and Governing Board meetings.	Completion Date: **06/30/2023** Status: **APPROVED** Date: **05/31/2023**

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S 53D1	Continued from page 23 Based on review of the facility's Medical Staff Bylaws, credential files (CF), and interview with staff (EMP) it was determined the facility failed to follow its established policy for the recommendation of clinical privileges to the Governing Body by the medical staff member for one of four credential files reviewed (CF4). Findings include: Review of the facility's "Medical Staff Bylaws, Liberty Eye Surgical Center" adopted and dated January 1, 2004, by the medical staff revealed "Article IV Appointment and Reappointment. 5.2 Appointment Authority: Appointments, denials and revocations of appointments to the medical staff shall be made as set forth in these bylaws but only after there has been a recommendation from the medical staff to the Governing Body." Review of the facility's Medical Staff Bylaws, Liberty Eye Surgical Center" adopted and dated January 1, 2004, by the medical staff revealed "	S 53D1		

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S 53D1	Continued from page 24 Article VI: Clinical Privileges: ... a member providing clinical services at this facility shall be entitled to exercise only those clinical privileges specifically granted. These privileges and services must be organization specific within the scope of any license, certificate, or other legal credential authorizing practice in this state and consistent with any restrictions thereon. Medical staff privileges may be granted, continued, modified, or terminated by the Governing Body only upon recommendation of the Medical Advisory Board..." Review on February 23, 2023, of CF4, a certified registered nurse anesthetist, revealed CF4 was approved for medical staff appointment by the Governing Board for a two-year period with privileges granted for "Endotracheal Intubation" beginning on March 10, 2022. Further review of CF4 revealed a document titled "CRNA-Anesthesia Scope Of Care" dated February 17, 2022, which the medical advisory board member had not signed the delineated privileges requested by CF4 listed on the document.	S 53D1		

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S 53D1	Continued from page 25 An interview conducted on February 23, 2023, at 12:55 PM with EMP1 confirmed the medical director as a member of the medical advisory board was to review, sign and date the requested privileges on the document titled "CRNA-Anesthesia Scope of Care" for CF4. Further interview confirmed there was no evidence of a documented signature and date by a member of the medical advisory board staff member or the medical director on the document titled "CRNA-Anesthesia Scope of Care" dated February 17, 2022, recommending approval of the delineated privileges requested by CF4. Cross Reference: 555.2: Tag 5200, Medical Staff Membership	S 53D1		

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S 53D1	Continued from page 26	S 53D1		
S 6142		S 6142		

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S 6142	Continued from page 27 561.25 Distressed drugs, devices and cosmetics 561.25 Distressed drugs, devices and cosmetics Drugs, devices and cosmetics which are outdated, visibly deteriorated, unlabeled or inadequately labeled, recalled, discontinued or obsolete shall be identified by the licensed pharmacist or responsible practitioner and shall be disposed of in compliance with applicable Commonwealth and Federal regulations. This REGULATION is not met as evidenced by:	S 6142	The Governing Board changed the policies titled "outdated and expired drugs" and "controlled substances" to reflect safe storage. Medical Director educated director of nursing on new policies. The director of nursing educated nursing staff on new policies at staff meeting on 04/25/2023. The governing board determined that medications that need to be disposed of are now to be kept in a box, labeled with the disposal company's name, in a locked cabinet that only the director of nursing has access to. When a clinical employee comes across a medication that is expired or needs to be disposed of they are to bring that medication to the director of nursing. A log containing the medication name, strength, quantity, expiration date and initials of the RN turning the medication in for disposal will be kept with the disposal box in a locked cabinet in the director of nursing's office. The director of nursing will audit the disposal box monthly and will present her findings at the quarterly	Completion Date: **06/30/2023** Status: **APPROVED** Date: **05/31/2023**

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S 6142	Continued from page 28	S 6142	quality committee and governing board meetings. Director of nursing educated clinical staff on electrode storage and safety on 04/19/2023. Clinical staff now date the electrode packs with the date opened and the expiration date and they close the bags with a storage clip after use. Electrode inventory and storage is audited weekly by an RN and then results are reviewed by the director of nursing. Weekly electrode audit results will be reviewed at the quarterly Quality and Governing Board meetings.	

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S 6142	Continued from page 29 Based on observation and interview with staff (EMP), it was determined Liberty Eye Surgical Center, Llc. failed to ensure outdated vials of medications (open and unopened) was maintained in a secured manner within the facility until disposal. Findings include: Observation conducted on February 23, 2023, at 2:15 PM with EMP1 and EMP2 of the facility's soiled workroom revealed a large open unsealed card board box with unopened outdated vials of intravenous and topical medications: Cefazolin 1 mg, an antibiotic (4) vials-expiration date of 11/2022, Timolol .5% Eye Drops (2) 5ml vials-expiration date of 12//2022 and 01/2023, Atropine Eye Drops 1%, (2) 5ml vials-expiration date of 12/08/2022 and 12/15/2022, Polymyxon Eye Drops (1) 5ml vial-expiration date of 12/2022, Rocuronium, a muscle relaxant, (10) 5ml vials-expiration date of 02/2023, Labetalol, an antihypertensive (1) 20 ml vial-expiration date of 03/2023 and Hydralazine, an antihypertensive, (24) 1ml vials-expiration date of	S 6142		

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S 6142	Continued from page 30 01/2023. A requested was made to EMP1 for the facility's policy for storage and disposal of expired medications. None was provided. An interview conducted on February 23, 2023, at approximately 2:40 PM with EMP1 and EMP2 confirmed the medication vials in the cardboard box in the soiled workroom were expired and nonclinical staff had access to the medications. EMP1 stated " 2. The environmental staff would have access to these expired medications in the soiled workroom because that staff has a master key to unlock the soiled workroom door. _____ Based on observation, review of facility policy, and interview with staff (EMP), it was determined the facility failed to ensure adhesive conductive foam electrodes were stored and utilized for the delivery of patient care according to the manufacturer's instructions for use.	S 6142		

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S 6142	Continued from page 31 Findings include: Observation on February 23, 2023, at approximately 2:30 PM with EMP1 and EMP2 of the nursing station revealed an open pouch of adhesive conductive foam electrodes with the following documentation "Opened 2/23/23". Further observation revealed the open pouch did not contain written documentation of the month/day/year of expiration once opened. Further observation of the contents of the open pouch of adhesive conductive foam electrodes revealed the pouch contained single adhesive conductive foam electrodes not in single use packaging. In addition, further observation revealed a stretcher and monitor not in use with numerous foam electrodes attached a cardiac monitor. A review of facility documentation " All-Purpose Foam Electrodes: Instruction for Use" revealed "Precautions: Do not use if package is opened or damaged...To prevent dry out, fold over the top of ECG (electrocardiograph) electrode pouch."	S 6142		

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S 6142	Continued from page 32 An interview conducted on February 23, 2023, at 2:35 PM with EMP1 and EMP 2 confirmed the unfolded open pouch of adhesive conductive foam electrodes did not contain written documentation of an expiration date on the opened pouch. Further interview confirmed the pouch contained numerous types of single adhesive conductive foam electrodes with no date of open and expiration date on each electrode. Further intervicew confirmed the single adhesive electrodes were not in a closed pouch and that the top of the pouch was not folded over to prevent dry out of its contents.	S 6142		
S 6744		S 6744		

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S 6744	Continued from page 33 567.41 MAINTENANCE SERVICE - Principle 567.41 Principle The ASF shall be equipped, operated and maintained to sustain its safe and sanitary characteristics and to minimize health hazards in the ASF for the protection of patients and employes. This REGULATION is not met as evidenced by:	S 6744	The approved document, "clean and safe inspection tool", was reviewed at the governing board meeting on 04/13/2023. The governing board voted to add "check all equipment and tools for rust" to the tool. The director of nursing was educated on the tool and will complete it weekly. The results for these weekly audits will be reported by the director of nursing at the quarterly quality, infection control and governing board meetings. The rusted casters on the OR stools were replaced 03/15/2023. A barrier between the ultrasonic sanitizer and the sink was installed in the decomposition room on 04/20/2023. The Governing Board voted to switch to disposable laryngoscopes at GB meeting on 04/13/2023. The 2 anesthesia carts have been audited and the scopes have been replaced with pre-sealed disposables. The medical director educated the director of nursing and all clinical staff on the new scopes on 04/19/2023. The anesthesia cart will be audited monthly by an RN to be sure everything is stored safely.	Completion Date: **06/30/2023** Status: **APPROVED** Date: **05/31/2023**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
S 6744	Continued from page 34	S 6744	All anesthesia cart audits will be reviewed by the director of nursing once completed. The director of nursing will present the audit findings at the quarterly infection control, quality, and GB meetings. The director of nursing will be responsible for the continued implementation of the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	39C0001165	A. BLDG: 00 B. WING:	04/11/2023

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S 6744	Continued from page 35 Based on a review of facility policy, an observation tour and interview with staff (EMP), it was determined the facility failed to ensure Liberty Eye Surgical Ambulatory Surgery Center (ASC) was maintained to sustain its safe and sanitary characteristics to minimize health hazards in the facility's Operating Rooms and Decontamination Room for the protection of employees and patients. Findings include: Review of facility policy " Infection Control Plan " last reviewed October 2, 2022, revealed " Responsibilities: The Governing Body authorizes the Infection Preventionist to institute appropriate infection control measures within the facility. This includes the authority to employ whatever methods necessary when, in their judgement, there is a reasonable possibility of immediate danger to any patient(s) or others in the facility. ...Physical plant personnel and the administrator is responsible to ensure all systems are in good working order."	S 6744		

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S 6744	Continued from page 36 1. Observation on February 23, 2023, at 2:14 PM with EMP2, in OR1 revealed a surgeon's stool with a brown reddish corrosive substance resembling rust on the bottom base of the stool and a brown reddish corrosive substance resembling rust on wheels of the stool. An interview conducted on February 23, 2023, at 2:16 PM with EMP2 in OR1 confirmed the brown reddish substance covering the bottom base and the wheels of the surgeon's stool was rust. 2. Observation on February 23, 2023, at 2:17 PM with EMP2, of the Anesthesia Cart in OR2 revealed a sealed see-through package containing a laryngoscope blade (instrument inserted into a patient's mouth to view the airway). Further observation revealed the sealed packaging did not contain information on the package as to whether the instrument was processed by use of sterilization and ready for patient use. Further observation revealed two unpackaged laryngoscope blades found in the drawers of the Anesthesia Cart.	S 6744		

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S 6744	Continued from page 37 An interview conducted on February 23, 2023, at 2:20 PM with EMP2, confirmed the Anesthesia Cart in OR2 contained a sealed see-through packing containing a laryngoscope blade with no information on the packaging as to whether the instrument was processed by use of sterilization and ready for patient use. Further interview confirmed the two unpackaged laryngoscope blades found in the drawers of the Anesthesia Cart in OR2 were not ready for patient use and appeared to be unsterilized. 3. Observation on February 23, 2023, at 2:40 PM with EMP2 and EMP3 in the Decontamination Room revealed an ultrasonic sanitizer unit utilized for processing surgical instruments position on a countertop next to a clinical sink utilized to dispose of clinical waste. Further observation revealed no separation barrier was mounted between the ultrasonic sanitizer unit position on the countertop and the clinical sink utilized to dispose of clinical waste.	S 6744		

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S 6744	Continued from page 38 An interview conducted on February 23, 2023, at 2:54 PM with EMP2 and EMP3 confirmed the ultrasonic sanitizer unit utilized for processing surgical instruments was position on the countertop in the Decontamination room next to the clinical sink utilized to dispose of clinical waster. EMP3 stated "I know we need a barrier between the ultrasonic sanitizer unit used for instrument processing and the clinical sink which is used to dispose of waste products. I have seen such a barrier at another job I used to work at."	S 6744		

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S 6744	Continued from page 39	S 6744		

Certified End Page

LIBERTY EYE SURGICAL CENTER, LLC

STATE LICENSE NUMBER: 17401501

SURVEY EXIT DATE: 04/11/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY